



Provider NEWS



A newsletter especially for Dean Health Plan providers

Be sure to share this information with your staff!

- RN, APNP, PA Staff
- Front Office Staff
- Administrative Staff
- Insurance Staff
- _____
- _____

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Nelson Braslow, MD

The Importance of Prior Authorization

An important goal of Medical Management is to ensure that members receive their 'rights.' In this instance 'rights' means the 'right care' for the 'right member' by the 'right provider' in

the 'right setting or level' and at the 'right price.' Utilization management at Dean Health Plan (DHP) works with providers and members to meet this objective. One process in achieving these 'rights' is prospective or prior authorization.

Prior authorization is a requirement for the member, provider or facility to notify DHP prior to delivery of service in order to receive approval that DHP will provide payment for the requested service as a covered benefit because the service is: a covered benefit in the members certificate; and Medically Necessary; and Not considered investigational or experimental by DHP. Not all services require prior authorization, but DHP reserves the right to deny a claim that does not meet one of the criteria listed above. DHP has the responsibility to designate which procedures, supplies, devices or drugs require a prior authorization.

On what basis or principles are services selected for prior authorization at DHP?

There are procedures which members or providers may request which may be covered under certain circumstances and not in others. The member and the provider deserve to know, prior to the delivery of service, whether DHP will pay for said service.

In general: The rationale for requiring prior authorization for any service includes one or more of the following (not an inclusive list):

1. Large financial commitment by the provider or member.

2. New or emerging technology, procedure, device or drug with narrow proven application and potential for high demand for non-proven indications.
3. A technology, procedure, device or drug that may only be a covered benefit under certain conditions.
4. Services (e.g. transplant) which require a high degree of coordination between the provider and member and/or among providers and/or where the plan can be of assistance to members with complicated or severe conditions.
5. Services which may be investigational/experimental for some indications and not for others.
6. Services which may be cosmetic for some indications and functional for others.

Some services, which are best prescribed or delivered by certain specialties, may only have a prior authorization in place when the requesting provider is either a Primary Care Provider (PCP) or a specialist who would not usually prescribe the technology, procedure, device and/or drug.

DHP has a fiduciary responsibility to administer the member's coverage contract *fairly and consistently* for each member according to the benefit coverage as outlined in their certificate. Exceptions for particular individual physicians or groups of physicians (*i.e. gold carding*) are difficult for the plan to administer, the member to understand and the provider community to manage and is not a strategy employed by DHP.

To be worth the burden, prior authorization must add material value. The value may accrue to different stakeholders unevenly, but must be present and clearly documented to keep a service on the prior authorization list. Among the potential values considered by DHP are: member support, coordination of complex disease and benefits, referral to case or disease management,

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compliance, cost mitigation, steerage to participating providers or facilities and correct claim payment.

Prior authorization in an Accountable Care Organization (ACO) must provide benefit for the entire system and the member. The burden created and frustration experienced by providers with the prior authorization process is heard clearly and repeatedly. The prior authorization list is currently being revised with the objective of reducing the number of services requiring prior authorization to a minimum. Each service currently requiring prior authorization is being reviewed to ensure that it adds material value and is the least burdensome way to achieve the benefit.

DHP is anxious to work with providers to reduce provider hassle and make the system work better.

Please email nelson.braslow@deancare.com or call (608) 827-4412 if you have recommendations or questions.

Change to IVR Implementation in 2011

Online Provider Portal Expanding to Meet Your Needs

After extensive research and focus groups with our providers, Dean Health Plan has made the decision not to proceed with our planned IVR go-live in 2011. Our customers have expressed their desire to have more online methods of communication in lieu of an IVR system. In response to these requests, we are currently working to enhance website improvement which will be available to contracted providers. We will reveal more about these enhancements as they become available, but in the meantime the NaviNet portal (*for those providers with access*) and online claim request form are still available for your convenience at deancare.com/providers.

High Risk Pregnancy Initiative

Dean Health Plan (DHP) is pleased to announce the High Risk OB initiative that has been developed to identify DHP members early in their pregnancies for timely intervention in those either at risk for complications associated with pregnancy or who have a history of high risk pregnancies. Members would qualify with a history of:

- ▶ Previous Delivery before 36 wks
- ▶ Severe Preeclampsia or HELLP Syndrome
- ▶ Uncontrolled Gestational Diabetes
- ▶ Preexisting Diabetes (Type 1 or 2)
- ▶ Hypertension on medication
- ▶ Previous Stillbirth
- ▶ Major Medical Conditions (e.g. Renal)
- ▶ Previous Infant with IUGR
- ▶ Infant with Birth Defect or Disabilities
- ▶ Genetic Syndrome
- ▶ Multiple Miscarriages
- ▶ DVT, Thrombophilia /Clotting Disorders
- ▶ Concerns about Medication Use
- ▶ Multiple Gestations

DHP is asking for the assistance of providers in order for this program to be successful in identifying these members and identifying them at the earliest possible time. Once the members are recognized to be high risk, DHP is asking that providers contact a DHP obstetrician or Maternal and Fetal Medicine at (608) 252-7458 for a consultation.

Also, DHP Case Management is available to DHP members who are identified as high risk during the pregnancy, post partum and during the inter-conception period. The OB Case Management program connects DHP members with a registered nurse to help them better understand their pregnancy and postpartum time, and provide them with assistance in managing their perinatal experience. DHP values the patient/physician relationship and supports the provider's care decisions for their OB patients. Members that choose to participate in Case Management are contacted by a RN at least monthly or more frequently as needed. Members are provided with individualized patient education materials when appropriate and followed closely in establishing behavioral and health related goals to improve, enhance and support healthy perinatal outcomes. Contact DHP at (608) 827-4343 to refer a member into OB case management.

Flu Shot Reminder

Members Can Receive \$26 Reimbursement

Dean Health Plan (DHP) will reimburse members up to \$26 for seasonal flu shots received from any provider, pharmacy or vaccination location. Please note that, as always, there is no charge when a member receives a flu shot from a DHP network doctor or location.

If a member receives a flu shot from a non-DHP network doctor or location, such as Walgreens or other retail flu shot site, they must download the reimbursement form located at deancare.com/flu, fill it out and submit it to DHP to receive the \$26 reimbursement.



Dean Health Plan Quality Improvement Program Helps Deliver the Best Care

The Dean Health Plan (DHP) Quality Improvement (QI) Program provides standards to measure and assess quality of clinical care and quality of service delivered to members.

The QI Program was developed to help achieve the following goals:

- ▶ Assure that health care and customer services are accessible and responsive to members' needs.
- ▶ Assure the provision of appropriate quality medical care to DHP members and their families.
- ▶ Assure the access and availability of such care through a network of primary and specialty care practitioners, inpatient and outpatient facilities, and ancillary service practitioners.
- ▶ Identify deficiencies in the care/service process and develop targeted interventions for improvement.
- ▶ Assure that behavioral health and medical care are integrated.
- ▶ Support improvement of members' health status through use of prevention, clinical practice guidelines, disease management programs, pharmacy initiatives, coordination of care and monitoring of under-utilization and over-utilization.
- ▶ Identify potential patient safety issues, integrate corrective processes into existing programs/initiatives and monitor for improvement.

The QI Program's functions include:

Annual Healthcare Effectiveness Data and Information Set* (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data collection and analysis. Results are submitted to the National Committee on Quality Assurance* (NCQA).

- ▶ Coordinate the collection, analysis and reporting of data used in monitoring and evaluating care, including quality, utilization, credentialing and member service functions delegated to associated organizations.
- ▶ Identify opportunities to improve care and develop quality improvement interventions.
- ▶ Identify and address substandard care.
- ▶ Identify and address issues regarding patient safety.
- ▶ Identify opportunities to improve the service delivered to our members and develop improvement interventions.
- ▶ Track the implementation and outcomes of quality improvement interventions.
- ▶ Evaluate the effectiveness of improving care and services.
- ▶ Conduct ongoing monitoring of care and services provided by physicians and other providers between re-credentialing cycles.

DHP has consistently met the goals of the QI Program and remains committed to these goals to maintain NCQA Excellent Accreditation.

* HEDIS is a set of standardized performance measures. CAHPS is a standardized survey that asks consumers and patients to report on and evaluate their experiences with health care. DHP reports their HEDIS and CAHPS scores on an annual basis to NCQA, which uses this information when accrediting health plans.

Web-based WI Blood Lead Registry is Now Available

The Department of Health Services has announced the release of the web-based Wisconsin Blood Lead Registry (WBLR). The WBLR is available through the Wisconsin Immunization Registry (WIR) and documents both the tests and the results. The lead registry is updated weekly and includes all tests that have been reported to the Wisconsin Childhood Lead Poisoning Prevention Program, including any tests performed at WIC agencies.

To gain access to the lead registry both the WBLR organizational security and confidentiality agreement and the WBLR individual security and confidentiality agreements have to be completed. These forms can be located on the WIR website www.dhfwir.org under the forms tab.

For Your Information

Member Letter Regarding Importance of a PCP & Patient Relationship

In January 2012 Dean Health Plan (DHP) members will receive a letter promoting the use of their primary care provider (PCP). As you know, one of the essential elements in health care is the relationship a member has with their PCP as they can assist with selecting the right choice of medical care. DHP strives to have accessibility and the highest quality of healthcare professionals and we thank you for being a partner in health.

Utilization Management Changes 2012

Dean Health Plan (DHP) is working on the following two major Utilization Management (UM) process improvements for 2012. We expect these changes will positively impact providers and members:

- ▶ Review of all current prior authorizations (PA) with the goal of reducing the number of prior authorizations that providers and staff must submit.
- ▶ Transition to evidence-based medical policies based on Milliman Care Guidelines®.

DHP understands the added administrative burden to providers and clinic staff associated with the submission and processing of PA requests. Until recently DHP has utilized a claims system with limited capabilities, requiring that many UM functions be dealt with using the PA process. In 2012, DHP is migrating to MetaVance®, a new automated claims system. It is DHP's goal to maximally leverage this new capability by transferring some old UM functions from the PA process to claims processing.

Also, in order to provide you and your patients with consistent, evidence-based medical necessity determinations, DHP is transitioning as much as possible to Milliman Care Guidelines®. Milliman Care Guidelines® are developed using the most rigorous evidence-based methodology with strict criteria for evidence classification and strength of evidence determinations. Milliman Care Guidelines® are used by more than 950 hospitals, seven of the eight largest US health plans, and 25 Centers for Medicare and Medicaid audit contractors. All content is reviewed annually and updated as necessary by doctors and nurses who cite more than 15,000 unique references, including peer review journals. Milliman epidemiologists then examine databases that cover a significant portion of the United States population to validate that these published research results are achievable in real-life situations.

Most Milliman Care Guidelines® use similar clinical criteria as those used by current DHP medical policies. However, there are some areas where Milliman criteria are materially different than current DHP medical policy criteria. In those instances, we have begun to elicit feedback from providers. We expect to continue this process throughout the year and into 2012. If you or your department would like to review Milliman Care Guidelines® on specific topics, or you would like us to meet with you or your practice group to discuss any of these issues, please do not hesitate to contact us.

For any inquiries or comments please contact Kathleen A. Sellnow, RN, Medical Policy Analyst at (608) 827-4463 or by email at kathleen.sellnow@deancare.com.



Vital Decisions Living Well Program Update

Dean Health Plan (DHP) partnered with Vital Decisions Living Well Program in December 2010, working with DHP Commercial and Medicaid members. The company specializes in providing outstanding health care counseling to individuals and their families who are experiencing serious illness. Vital Decisions is an outreach program providing telephonic counseling offered at no cost to the member.

The Living Well Program, which is a voluntary, patient-centered service, will:

- ▶ Help individuals identify their quality of life preferences and values
- ▶ Assist patients in actively and effectively communicating their priorities to family and physicians
- ▶ Ensure that more effective shared decision making processes occur

This is an outreach program—participants will be notified directly by Vital Decisions. This type of counseling can be extremely beneficial and help support participants in making important health decisions.

Eligible members are identified in three ways:

- ▶ Health Plan case manager referrals
- ▶ Claims-based algorithm identification (most are identified in this fashion)
- ▶ Physician referrals

As of September 2011, 234 DHP members engaged in this program and are highly satisfied with the program. In fact, on a one to five scale with five being the highest, the question on how likely are you to recommend Vital Decisions to others in a similar situation, the median score was five. Please feel free to recommend this program to your patients with a serious illness by calling DHP at (800) 356-7344, extension 4132. For any other questions, please contact Dr. William Panek, Senior Medical Director, DHP, at (608) 827-4262 or Karen Lockard, RN, Clinical Program Analyst, DHP, at (608)827-4274.

Preventive Services *and Federal Health Care Reform*

The Patient Protection & Affordable Care Act (also known as Federal Healthcare Reform) passed in March of 2010 included a number of provisions that were implemented in late 2010 and early 2011. In the “first wave” of provisions that were implemented in 2010, none was perhaps more complex than the “preventive services” provision. While most health plans already set aside a listing of preventive services prior to health care reform, this provision sought to outline what services health plans should consistently consider as “preventive” and went on to mandate that the plans are prohibited from applying any cost sharing to the services (or in other words, these services are to be covered at 100 percent). While the intent of this provision makes sense to most people, the implementation of this provision was nowhere near as straightforward.

On the commercial plan side, there are no coding guidelines or clearly defined explanations of the realm of services that must be covered, and the provision relies on high level screening guidelines such as the United States Preventive Services Task Force, which were not written as payment guidelines but as recommended screening guidelines. For Medicare plans, the status is clearer since CMS drives payment guidelines and Medicare has clearer coding guidelines.

So what does this mean to you as a provider? You may encounter more and more commercial health plan patients in the upcoming months who are confused about what is covered under the preventive services provision. We certainly do not expect you to be quoting coverage and benefits to members during a visit but we have a couple of suggestions if you want to direct your patients to the right resources to help ease their confusion.

The federal health care reform website, www.healthcare.gov, is an excellent resource for patients on preventive services as well as the other provisions of health care reform that might impact them. On this site, they include a full listing of the preventive services guidelines that are eligible for 100 percent coverage, which health plans are required to follow. If a service is not on this listing, it is a reasonable assumption for the member to make that the service will not be eligible for 100 percent coverage.

If the member has Dean Health Plan (DHP) insurance, please direct them to the DHP Customer Care Center deancare.com where they will be able to find out more information about what services are covered under the preventive services provision and ask specific questions related to their situation.

Lastly, please be aware that members seem to be confused between services that are recommended for them by their primary care provider versus services that are recommended in general for various populations under the federal health care reform provisions. Members have mistakenly thought that because their provider said they needed to have this screening, test or service, it is automatically considered “preventive” and covered at 100 percent. In simple terms, the driver of the 100 percent coverage is not that the service occurred during an annual physical; the determining factor is whether the service falls within the screening guidelines outlined in the federal health care reform law. The health plan still covers screening, exams, tests that don't fall under the health care reform provisions; the difference for the member will be whether cost sharing will apply to the service or not.

We appreciate your assistance in the effort to reduce confusion about the complex health care reform provision. We are hopeful that the federal government will release additional payment guidelines in the future, but in the meantime, we're focusing our efforts on trying to better educate our members about what falls under this provision.

Refund Check Process for Providers

Refund checks should be submitted by a provider anytime it is requested by Dean Health Plan (DHP) due to overpayment on a claim, recoupment that is made, or any time a provider is requesting DHP to reprocess a claim which will result in a refund to Dean Health Plan.

What should be included with a refund check?

- ▶ The refund check submission form found can be found in the forms section at deancare.com/providers.
- ▶ Include all details regarding the claim and why the refund is being submitted.
- ▶ Include supporting documentation such as an EOP, refund request letter from DHP, other primary carrier EOB, etc.

What happens once the check is received by DHP?

1. Each check is worked and applied to the appropriate claim(s) based on the information received from the provider.
2. The claim is re-processed if required, otherwise brought to the appropriate balance based on the refund amount.
3. The details of the check are provided to our Finance Department and finalized.

Thirty days should be allowed for processing once received in-house. If a claim has to be reprocessed (if it was not already recouped by DHP) the providers should look for that on their EOP following the 30 day processing timeframe. If a claim has already been recouped the refund will be applied to the negative balance and the provider will not receive an updated EOP. If you have questions about this process please call the Customer Care Center.

Medical Policy Update

Highlights of recent medical policy revisions as well as any new medical policies approved by the Dean Health Plan (DHP) Medical Directors Committee are shown below. The Medical Director Committee meetings take place the fourth Thursday of each month. Contribution by specialists during the technology assessment of medical procedures and treatments is appreciated.

To view all DHP medical policies, go to deancare.com, ► For Providers ► Medical Policy Search. This website is updated as the medical policies become effective. If you have questions regarding any medical policy or would like copies of a complete medical policy, please contact the Customer Care Center at (800) 279-1301. All other DHP clinical guidelines used by the Medical Affairs Division, such as Milliman Care Guidelines and the American Society of Addiction Medicine, are accessible to the provider upon request. Contact Medical Affairs Division at (800) 356-7344 ext. 4463 to request the clinical guidelines.

Coverage of any medical intervention discussed in a DHP medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate. A verbal request for a referral does not guarantee authorization of the referral or the services. After a NaviNet or written referral request has been reviewed in the Medical Affairs Division, either a NaviNet or printed notification is sent to the requesting provider and member.

Note that prior authorization through the DHP Medical Affairs Division may be required for treatments or procedures. For members enrolled in DHP Medicare Gold basic supplemental plans, the Medicare benefit coverage supersedes DHP's medical policies.

Please note, some of the imaging policies may apply to DHP's Self-Funded ASO groups only. For all other DHP members (HMO, MA, and POS/PPO) please contact National Imaging Associates (NIA). Details about the radiology prior authorization program can be found online at deancare.com/providers/patient-care.

The following medical policies were updated:

Viscosupplementation Therapy MP9117--effective 02/01/2012

Viscosupplementation therapy will no longer be covered for TMJ. The brand names in Section 2.0 have been removed. If medically necessary, one repeat series of treatment will be allowed for each knee every 12 month period. Temporomandibular Disease MP9272 will be updated to reflect these changes.

Auditory Brain Stem and Cochlear Implants MP9016-effective 02/01/2012

The clinical criteria have been updated. Upgrades and replacements for both cochlear and auditory brain stem implants require PA.

Oxygen Therapy MP9104-effective 02/01/2012

The clinical criteria have been updated. Prior authorization is still required for out of network services.

Lymphedema Treatment MP9119-effective 02/01/2012

The prior authorization has been removed for lymphedema treatment. The lymphedema pumps will continue to require prior authorization.

Blepharoplasty or Blepharoptosis (Eyelid Surgery) MP9214-effective 02/01/2012

The clinical criteria have changed. Medical necessity criteria now require ptosis interfering with central 40 degrees of vision (i.e. 20 degrees above and below fixation). Frontal photos which document the medical necessity of any eyelid repair must be included with any prior authorization request.

Self Monitoring Of Warfarin Therapy (INR Testing) MP9263-effective 02/01/2012

The clinical criteria for home INR monitoring include the need for anticoagulation for 6 months or longer with oral vitamin K antagonist (eg, warfarin); and oral anticoagulation therapy needed for 3 months or longer.

Meniett Device for Meniere's Disease MP9284-effective 02/01/2012

The policy will be discontinued, and this device will no longer be covered.

Sacral Nerve Stimulation for Urinary and Fecal Incontinence MP9113—effective 02/01/2012

Implantable sacral nerve stimulation for fecal incontinence is now covered. Implantable sacral nerve stimulation for urinary or fecal incontinence will no longer require prior authorization.

Bone Growth (Osteogenesis) Stimulators MP9076—effective 02/01/2012

The clinical criteria have been updated. Prior authorization will continue to be required.

Cardiac Rehabilitation (Phase II) MP9079—effective 02/01/2012

The policy will be deleted. Prior authorization will no longer be required for phase II cardiac rehabilitation.

Home Blood Glucose Monitors MP9091—effective 02/01/2012

Prior authorization will no longer be required for audio, talking and intermittent home glucose monitors. Home continuous glucose monitors will continue to require prior authorization.

Breast Pumps MP9092—effective 02/01/2012

The policy will be deleted. Breast pumps will no longer be covered as they are available over the counter. This change does not affect BadgerCare participants.

Repairs/Replacement of Durable Medical Equipment MP9106-effective 04/01/2012

The policy will be deleted, the information will now be found in the Member Certificate. There are no changes in coverage criteria.

Electrical Stimulation for Pain Control MP9286—effective 02/01/2012

Neuromuscular electrical stimulation will no longer be a covered service.

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Chelation Therapy MP9311—effective 02/01/2012

The policy will be deleted. Only chelation therapy for lead poisoning will be covered.

Intrathecal Pump Implantation MP9278—effective 02/01/2012

Implantable intrathecal pumps will require prior authorization and are covered for spasticity, dystonia and pain due to malignancy when the clinical criteria are met in the policy. Intrathecal pumps are not covered for acute or chronic pain.

Meniscal Allografts MP9277—effective 02/01/2012

Collagen meniscus transplants are considered not medically necessary and are not a covered service. The current medical literature does not demonstrate improved clinical outcomes. Meniscal allografts will continue to require prior authorization.

Epidural Steroid Injections MP9362—effective 02/01/2012

The clinical criteria for epidural steroid injections will now reside in a separate policy. The checklist is also available on the last page. Cervical epidural steroid injections are considered not medically necessary and will no longer be covered. Lumbar epidural

steroid injections will continue to require prior authorization and are limited to no more than 4 in one year.

Intensity Modulated Radiation Therapy (IMRT) MP9426—effective 02/01/2012

This new policy takes the information for IMRT out of one policy and it will now become a separate policy. There are no clinical changes and prior authorization is still required.

Interventional Procedures for Pain MP9383—effective 02/01/2012

There are several changes for this policy. They include:

- ▶ Medial branch blocks and Chymopapain will no longer be a covered service
- ▶ Trigger point injections and the microdiscectomy sections will be removed; the services will remain covered without prior authorization.

The separate procedures each have their own medical policy. This policy will be deleted. The separate policies are: Lumbar Discography MP9427, Epidural Steroid Injections MP9362, Facet Joint Injections MP9428, Kyphoplasty MP9429, Spinal Cord or Dorsal Column Stimulator MP9430. The information

for spine cages will be included in the policy titled: Artificial Disc Systems MP9364.

Continuous Passive Motion Machine (CPM) MP9096—effective 02/01/2012

Continuous passive motion machines will no longer be covered following shoulder surgery. The medical literature does not support improved clinical outcomes for the use of a CPM following shoulder surgery.

The following medical policies were discontinued:

Meniett Device for Meniere's Disease MP9284

Chelation Therapy MP9311

Electrical Stimulation for Pain Control MP9286

Repairs/Replacement of Durable Medical Equipment MP9106

Breast Pumps MP9092

Cardiac Rehabilitation (Phase II) MP9079

X-Stop Interspinous Decompression System MP9354

Platelet Rich Plasma MP9392

Cord Blood Storage MP9009

Focus on Fraud and Abuse Prevention

The Patient Protection and Affordable Care Act of 2010, or Health Care Reform, contains significant requirements related to health care fraud and abuse. The requirements impact nearly every sector of the health care industry, including health care providers. The requirements include new rules and resources designed to assist federal and state agencies in their efforts to identify, prevent and prosecute health care fraud and abuse. Governor Scott Walker recently created a new position within the Wisconsin Department of Health Services to root out fraud, waste and abuse in Medicaid and other entitlement programs.

Dean Health Plan (DHP) acknowledges the importance of federal and state anti-fraud initiatives and takes the fight against health care fraud very seriously. Overall, health care fraud and abuse translates into unnecessary

medical spend, higher premiums and increased out-of-pocket expenses for DHP members. It is our responsibility to constantly monitor health care fraud; DHP continually examines the following to ensure compliance and accuracy.

- ▶ Intentional misrepresentation of false information for reimbursement.
- ▶ Upcoding, unbundling, duplicate services and not performing services.
- ▶ The key element is knowingly or intentionally committing an act(s).
- ▶ Overutilization of medical diagnosis with the knowledge that the service provided is not necessary.

In the event SIU identifies potential fraud and abuse, SIU may request medical documentation to ensure proper coding and claim submission. During SIU's review,

DHP will not provide reimbursement of suspect claims until appropriate documentation is received which substantiates reimbursement. SIU may also interview its providers and members regarding services performed. If evidence indicates fraud or abuse has occurred, SIU may initiate further action, including referral of the matter to appropriate local, state or federal agencies.

Of course, the majority of provider health care fraud is committed by a very small minority of providers. The actions of this minority erode the reputation of the most trusted and respected members of our society—our physicians and other health care providers. Please join DHP in the fight against fraud. For more information, please contact Scott Strain at (608) 827-4028.

DHP Pharmacy & Therapeutics Committee

New Drug Review Summary

Victrelis (boceprevir) 200mg capsules.

A HCV NS3/4A protease inhibitor for the treatment of genotype 1 chronic hepatitis C virus (HCV) in combination with peginterferon alfa and ribavirin.

Clinical Considerations: VICTRELIS represents a clinical advance in the treatment of chronic HCV, increasing SVR rates over peginterferon alfa and ribavirin alone. Dosing algorithms may allow for decreased treatment duration, but can be complex and require HCV RNA levels be drawn at various time points. VICTRELIS has not been studied in HBV or HIV co-infected patients and cannot be used as monotherapy.

Formulary Decision: The committee voted to add Victrelis to formulary, 2nd tier, with a prior authorization for gastroenterology and infectious disease physicians only.

Incivek (telaprevir) 375mg capsules

A HCV NS3/4A protease inhibitor for the treatment of genotype 1 HCV in combination with peginterferon alfa and ribavirin.

Clinical Considerations: INCIVEK represents a clinical advance in the treatment of chronic HCV, increasing SVR rates over peginterferon alfa and ribavirin alone. Dosing algorithms may allow for decreased treatment duration and require HCV RNA levels be drawn at various time points. INCIVEK has not been studied in HBV or HIV co-infected patients and cannot be used as monotherapy.

Formulary Decision: The committee voted to add Incivek to formulary, 2nd tier, with a prior authorization for gastroenterology and infectious disease physicians only.

Zytiga (abiraterone) 250mg tablets

ZYTIGA, used in combination with prednisone, is indicated for patients with metastatic castrate resistant prostate cancer (CRPC) who have received prior chemotherapy containing docetaxel.

Clinical Considerations: The use of abiraterone is well defined according to NCCN guidelines. Category 1 evidence supports use after use of docetaxel (TAXOTERE). Abiraterone is an advancement in the treatment of terminal metastatic CRPC.

Summary: ZYTIGA offers a therapeutic option for adult patients with metastatic CRPC who have received prior chemotherapy containing docetaxel.

Formulary Decision: The committee voted to add Zytiga to formulary, 2nd tier, for approved indications only.

Natroba (spinosad) 0.9% topical solution

A pediculicide indicated for the topical treatment of head lice infestations in patients four (4) years of age and older.

Clinical Considerations: NATROBA demonstrated clear superiority to the commonly used OTC drug. In vitro data from a small trial also showed a lack of resistance in permethrin resistant lice. Lack of retreatment requirement supports ovicidal activity. A QL should be used to prevent one prescription from being used to treat an entire family.

Formulary Decision: The committee voted to add Natroba to formulary, 2nd tier, with a quantity level limit of 120ml per Rx.

Lastacaft (alcaftadine) 0.25% ophthalmic solution

An ophthalmic histamine receptor antagonist indicated for the prevention of itching associated with allergic conjunctivitis.

Clinical Considerations: LASTACAFT is the 8th product in the ocular antihistamine class, although it offers a once-daily dosing option that is only available in one other product (PATADAY). It is pregnancy category B and approved down to age 2

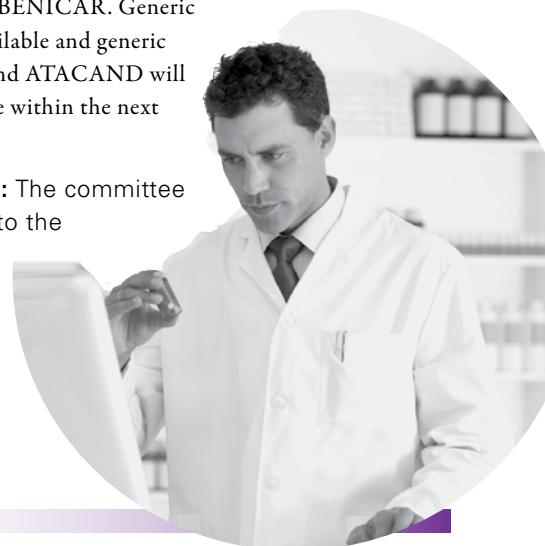
Formulary Decision: The committee voted to add Lastacaft to the formulary, 3rd tier, with a generic epinastine step edit.

Edarbi (azilsartan medoxomil) 40mg, 80mg tablets

Angiotensin Receptor Blocker FDA approved for the treatment of hypertension.

Clinical Considerations: EDARBI is the 8th angiotensin receptor blocker. The product offers a once-daily dosing regimen with a greater efficacy in blood pressure reduction than maximum recommended doses of DIOVAN and BENICAR. Generic losartan is currently available and generic DIOVAN, AVAPRO, and ATACAND will have their patents expire within the next 12 months.

Formulary Decision: The committee voted to add Edarbi to the formulary, 3rd tier, with a generic losartan step edit.



Quality Spotlight

Documentation Tips for HEDIS 2012

February marks the beginning of HEDIS 2012 and Dean Health Plan (DHP) reviewers will again be visiting clinics to gather data from medical charts. Reviewers have to follow strict rules when gathering data for HEDIS. Improving rates can sometimes be as simple as changing the way some services are documented. Here are some helpful documentation tips identified during last year's visits that can help HEDIS 2012 be even more successful.

The Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents is a measure that requires specific documentation. Reviewers can accept information if the chart contains the following documentation:

BMI:

- a. BMI percentile documented and dated
- b. BMI percentile plotted on the age-growth chart and dated

Nutrition Counseling must be documented as:

- a. Discussion of the current nutrition behaviors (e.g. eating habits and recommended actions)
- b. Checklist indicating nutrition advice was given
- c. Patient received educational materials on nutrition
- d. Counseling or referral for nutrition education

Physical Activity counseling must be documented as:

- a. Discussion of current physical activity (e.g. exercise routine or sports activities)
- b. Checklist indicating physical activity was encouraged
- c. Patient received education materials on physical activity
- d. Counseling or referral for physical activity

Examples of documentation that reviewers are unable to collect:

- ❶ The chart only contains height and weight or the absolute BMI
- ❷ Notations of health education, anticipatory guidance or health education materials given without mention of either nutrition or physical activity
- ❸ Notations of cleared for gym class without documentation of a discussion

Some HEDIS measures require us to collect evidence of select medications taken by a patient during a specific timeframe. Reviewers commonly find medication data in one of two ways; listed in the actual visit notes or on an active medication list. An active medication list can be used if it contains the date the medication was first prescribed, dates medications were discontinued, and has documentation of when the list was reviewed by a prescribing provider.

Implementing these tips into clinical documentation can have a positive impact on measurement rates and can help HEDIS 2012 be even more successful.

Health Care Reform: Adverse Benefit Determinations

Effective January 2012, you will begin to see new language on prior authorization letters and EOPs following recent amendment to Health Care Reform requirements around adverse benefit determinations. The initial reform language indicated all notices of adverse benefit determinations and final internal adverse benefit determinations include the diagnosis and treatment codes and their corresponding meanings has been modified. The amended regulations indicate that this information does not need to be automatically provided, but that these notices must now include a statement that the procedure and diagnosis codes and corresponding descriptions be made available upon request. If requested, health plans must provide the information as soon as possible.

As a result of this new regulation, the following language will appear on EOPs and prior authorizations:

If you think a coding error may have occurred, you have the right to obtain the billing and diagnosis code descriptions associated with this request/service. You can request this information by contacting Dean Health Plan Customer Care Center at (800) 279-1301.

What does this mean to you? As a Dean Health Plan (DHP) provider, you will be required provide the primary procedure code and primary diagnosis code on all prior authorization requests submitted. DHP members may contact you to confirm the procedure code and corresponding description match the services rendered, or to be rendered in the case of a prior authorization, in an effort to rectify an adverse determination. If you have any questions contact your Provider Relations Specialist.

Dean Health Plan Generic Sampling Program *Generics First Fill Free Program*

The Dean Health Plan (DHP) Generic Sampling Program was created to encourage patients to use generic drugs. When a patient is prescribed a qualifying generic drug, the copay for the first prescription fill is waived. Much like a branded sample, the member has no out-of-pocket expense for the first 30 days of treatment.

The following list of drugs we recently added to the list of qualifying drugs in October 2011.

Generic Choice(s)	Branded Choice(s)
fluticasone nasal spray (Flonase)	Nasonex, Veramyst
epinastine ophthalmic (Elestat)	Pataday
azelastine ophthalmic (Optivar)	Pataday
Alaway (ketotifen) OTC eye drops	Pataday
pantoprazole (Protonix)	Dexilant
oxybutynin, XL (Ditropan, XL)	Vesicare, Toviaz

In addition to the availability of these new drugs, below is a summary of other qualifying drugs:

- ▶ losartan/HCTZ
- ▶ metformin
- ▶ citalopram
- ▶ glipizide
- ▶ fluoxetine
- ▶ glyburide
- ▶ paroxetine
- ▶ lisinopril
- ▶ simvastatin
- ▶ enalapril
- ▶ pravastatin
- ▶ metoprolol
- ▶ lovastatin
- ▶ atenolol
- ▶ omeprazole 20mg
- ▶ doxazosin
- ▶ loratadine OTC
- ▶ cetirizine

To have your patient benefit from this program, simply prescribe a drug from the list. New prescriptions written for qualifying drugs are automatically filled at a \$0 copay.

Changes to 90-Day Retail Program

In April, Dean Health Plan (DHP) will implement a change to the 90-day retail program. For a select group of members, a 90-day supply will now be required for generic, maintenance medications. After a patient has received three 30-day prescriptions for generic maintenance medications, DHP will require that the patient switch to a 90-day supply.

At the point of service, Navitus will be communicating to our retail pharmacy network which prescriptions need to be switched to a 90-day supply. The pharmacy will then contact the physician office, to get approval to increase the prescription from a 30 day supply to a 90 day supply.

If the physician determines that a 90 day supply is not appropriate for the patient, or if the patient is unable to afford the out-of-pocket copay or coinsurance, an exception to these changes will be made. Please contact your Provider Relations Specialist with any questions.



HIPAA 5010 *Transaction Sets Readiness*

Dean Health Plan (DHP) will begin accepting new HIPAA-compliant 5010 transaction sets effective January 1, 2012. Thank you to all provider network hospitals and providers who submitted test files to help prepare for this major initiative.

As part of the overall transition to the new 5010 transaction sets, we would like to remind all providers of the following key dates:

- ▶ January 1, 2012: CMS-required effective date for implementation of 5010 transaction sets.
- ▶ January 1, 2012: State of Wisconsin Medicaid will begin accepting HIPAA-compliant 5010 transaction sets.
- ▶ April 1, 2012: CMS will begin assessing penalties for all parties who fail to utilize 5010 transaction sets.
- ▶ We will begin making outreach efforts to those providers who are non-compliant with HIPAA 5010 requirements throughout December so that compliance is achieved by January, 2012.

We will continue to provide status updates relative to the above milestones for DHP's implementation of the HIPAA-compliant 5010 transaction code sets. In the meantime, if you have any questions relative to these changes, please contact your Provider Relations Specialist.

Statement of Policy

Dean Health Plan's Utilization Management (UM) decisions are based solely on appropriateness of care and service and the existence of coverage. Dean Health Plan does not reward practitioners or other individuals making UM decisions for issuing denials of coverage or service care, nor does it provide financial incentives for UM decision makers which encourage decisions that result in underutilization. A copy of this statement is available by contacting the Customer Care Center at 800-279-1301.



BadgerCare Plus

Wisconsin Medicaid Announces Electronic Health Record Incentive Program

Wisconsin Medicaid has published the requirements for the Electronic Health Record (EHR) Incentive program. The State is accepting applications from certified Medicaid providers and hospitals to implement Electronic Health record technology and provide meaningful use of this technology.

Providers are allowed to participate in either the Medicaid EHR or the Medicare EHR program, but not both. Providers are allowed to switch their election once during the six year program. A minimum of 30 percent of patients (in a 90 day period) of an individual or group practice must be Medicaid members in order to be eligible for the Medicaid EHR Incentive program. The minimum percentage of Medicaid patients is lower for Pediatricians.

For hospitals, children's hospitals are allowed only to participate in the Medicare or Medicaid EHR program. However, critical access and acute care hospitals can participate in both programs simultaneously. Similar to the professional program, there is a minimum percentage of patients that must be Medicaid patients.

To receive payment for 2011, applications from professionals or group practices are due to Wisconsin Medicaid by December 31st, 2011. Providers are eligible for funding up to six years. For hospitals, funding is available for three years and the application due date for 2011 has been extended until December 31. Applications received after December 31 will have a start date of 2012 for the three year project.

Program requirements are described in the following ForwardHealth Updates published on the ForwardHealth portal at www.forwardhealth.wi.gov.



Dean Health Plan, Inc.
1277 Deming Way
Madison, WI 53717

CUSTOMER CARE
CENTER

(800)279-1301

Monday through Thursday
7:30 a.m. to 5:00 p.m.

Friday

8:00 a.m. to 4:30 p.m.

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Otherwise, please contact your Provider Relations Specialist if you know someone in your organization that would benefit from receiving Provider News by US Mail. Your suggestions on how to improve the newsletter are welcome.

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